Comagine Health
Formerly Qualis Health and HealthInsight

SUD Residential Treatment Provider - Quick Reference Document

When are Prior Authorization Requests to be Submitted and what Documentation is Required?

- **Direct Fee For Service**:
  - **By Day 7** – *Co-Triage, Continuum Assessments, and SUD Plan of Care*
  - **Day 14** – *Bi-Weekly Clinical Summary of Progress*
  - **Day 28** – *Updated Continuum & Bi-Weekly Clinical Summary of Progress*
  - **Every 14 days following** – *Bi-Weekly Clinical Summary of Progress and any documentation updates (i.e. Continuum or SUD Plan of Care)*

- **MCO Transition to Fee For Service**:
  - **3 days prior to the end of approved in lieu of days** – *Continuum, Plan of Care, MCO Approval letter, and Bi-Weekly Clinical Summary of Progress (including most recent 14 days of treatment) ***If less than 14 days of treatment at submission, please include all existing days****
  - **Every 14 days following** – *Bi-Weekly Clinical Summary of Progress and any documentation updates (i.e. Continuum or SUD Plan of Care)*

*****If Continuum recommends Co-Occurring Enhanced Services, the following additional documentation is required with Prior Authorization Requests when an external agency is providing mental health services:**

- *Behavioral Health Assessment (Only to be submitted once, unless updated)*
- *Behavioral Health Plan of Care (Only to be submitted once, unless updated)*
- *Behavioral Health Progress Notes*
- *Completed Co-Occurring Enhanced portion of the Bi-Weekly Clinical Summary of Progress*

What are important documentation requirements?

- **Providers can submit up to 3 days prior to the Authorization Request start date (***within first 7 days for initial patient admission review***)**
- **Continuum Assessment**
  - *Must be completed:*
    - *Every 4 weeks (28 days). If a Continuum assessment will be more than 28 days old at time of request start date, a Continuum update must be completed and submitted with the Prior Auth request*
    - *Within 3 days prior to a patient discharge (unless patient leaves AMA)*
    - *Upon transition to new facility or level of care (unless the Agency stays the same)*
- **Plan of Care**
  - *Must be completed by day 7 of treatment stay*
  - *At a minimum, the Plan of Care should be updated in accordance with Ch. 63 (6339.3) requirements, including time frames.*
  - *Any updates to the Plan of Care, should be submitted with the next Prior Authorization Request*
- **Bi-Weekly Clinical Summary of Progress**
  - *Must be completed every 14 days (except for when under MCO Coverage)*
  - *Please complete all applicable information for each 14-day period*
  - *For shortened periods (< 14 days of treatment), please include all treatment days (ex. A 12-day treatment period = 12 days included in Bi-weekly Clinical Summary of Progress)*

Contact Information for Provider Questions? Comagine Health DC Office: **1-800-251-8890**